STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155477	A. BUILDING _____ B. WING _____	09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANE HOUSE	1000 LANE AVE CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for a Recertification and State Licensure survey.

Survey dates: September 7, 8, 9, 10, 11, 12, 2014

Facility number: 000462
Provider number: 155477
AIM number: 100275380

Survey team:
Mary Weyls RN TC
Laura Brashear RN
Vickie Nearhoof RN
Brooke Harrison RN (September 8, 9, 10, 11, 12, 2014)

Census bed type:
SNF/NF: 45
Total: 45

Census payor type:
Medicare: 4
Medicaid: 35
Other: 6
Total: 45

Lane House is in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 - 3.1, in regard to the Recertification and State Licensure survey.

Quality Review 09/15/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE